

MINUTES OF THE PUBLIC HEALTH COUNCIL

Meeting of June 10, 2015

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

**PUBLIC HEALTH COUNCIL
MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
Henry I. Bowditch Public Health Council Room, 2nd Floor
250 Washington Street, Boston MA**

Docket: Wednesday, June 10, 2015 9:00 AM

1. ROUTINE ITEMS:

- a. Introductions
- b. Updates from Commissioner Monica Bharel, M.D.
- c. Record of the Public Health Council Meeting May 13, 2015 **(Vote)**

2. DETERMINATION of NEED

- a. DoN #1-3C41 Noble Hospital (Westfield) transfer of ownership
Baystate Medical Center seeks to acquire Noble Hospital. **(Vote)**

- b. DoN #3-3C36 Lawrence General Hospital – significant change to previously approved
construction project **(Vote)**

3. PRESENTATIONS

- a. Serious Reportable Events update

The Commissioner and the Public Health Council are defined by law as constituting the Department of Public Health. The Council has one regular meeting per month. These meetings are open to public attendance except when the Council meets in Executive Session. The Council's meetings are not hearings, nor do members of the public have a right to speak or address the Council. The docket will indicate whether or not floor discussions are anticipated. For purposes of fairness since the regular meeting is not a hearing and is not advertised as such, presentations from the floor may require delaying a decision until a subsequent meeting.

Public Health Council

Presented below is a summary of the meeting, including time-keeping, attendance and votes cast.

Date of Meeting: Wednesday, June 10, 2015

Beginning Time: 9:14 AM

Ending Time: 10:37AM

Attendance and Summary of Votes:

Board Member	Attended	Item 1c Minutes of the April 8, 2015	Item 2a DoN #1-3C41 Noble Hospital (Westfield) transfer of ownership	Item 2b DoN #3-3C36 Lawrence General Hospital
Monica Bharel	Yes	Yes, as Amended	Yes	Yes
Edward Bernstein	Yes	Yes, as Amended	Yes	Yes
Derek Brindisi	Absent	Not Voting	Not Voting	Not Voting
Harold Cox	Absent	Not Voting	Not Voting	Not Voting
John Cunningham	Absent	Not Voting	Not Voting	Not Voting
Michele David	Yes	Yes, as Amended	Yes	Yes
Meg Doherty	Absent	Not Voting	Not Voting	Not Voting
Michael Kneeland	Yes	Yes, as Amended	Yes	Yes
Paul Lanzikos	Yes	Yes, as Amended	Yes	Yes
Denis Leary	Yes	Yes, as Amended	Yes	Yes
Lucilia Prates-Ramos	Yes	Recusal	Yes	Yes
Jose Rafael Rivera	Yes	Yes, as Amended	Yes	Yes
Meredith Rosenthal	Yes	Yes, as Amended	Yes	Yes
Alan Woodward	Yes	Yes, as Amended	Yes	Yes

Board Member	Attended	Item 1c Minutes of the April 8, 2015	Item 2a DoN #1-3C41 Noble Hospital (Westfield) transfer of ownership	Item 2b DoN #3-3C36 Lawrence General Hospital
Michael Wong	Absent	Not Voting	Not Voting	Not Voting
Summary	10 members attended	9 Approved as amended with votes	10 Approved with votes	10 Approved with votes

PROCEEDINGS

A regular meeting of the Massachusetts Department of Public Health's Public Health Council (M.G.L. c. 17, §§ 1, 3) was held on Wednesday June 10, 2015 at the Massachusetts Department of Public Health, 250 Washington Street, Henry I. Bowditch Public Health Council Room, 2nd Floor, Boston, Massachusetts 02108.

Members present were: Department of Public Health Commissioner Monica Bharel (chair); Edward Bernstein, MD; Michele David, MD; Michael Kneeland, MD; Paul Lanzikos; Denis Leary; Lucilia Prates-Ramos; Jose Rafael Rivera; Meredith Rosenthal, PhD; and Alan Woodward, MD.

Absent member(s) were: Derek Brindisi; Harold Cox; John Cunningham, PhD; Meg Doherty; and Michael Wong, MD.

Also in attendance were Elizabeth Scurria Morgan, Acting General Counsel at the Massachusetts Department of Public Health and Jennifer Barrelle, Interim Deputy Chief of Staff for Policy and Regulatory Affairs at the Massachusetts Department of Public Health.

Commissioner Bharel called the meeting to order at 9:14 AM and made opening remarks before reviewing the agenda. The Commissioner's remarks included the following items:

Updates from Commissioner Monica Bharel, M.D., MPH

1. The Commissioner noted that, due to a scheduling issue, the planned Steward monitoring presentation would be postponed until a later date.
2. The Commissioner recognized and congratulated Ben Wood, a Healthy Community Design Coordinator at the Department of Public Health, who won the Public Service Award at the annual MA Public Health Association's annual breakfast. She noted that this award is given to an individual "for inspiring commitment to integrating public health perspectives into all aspects of our communities."
3. The Commissioner provided the Council with an update on work being done to address the opioid crisis. She noted that in listening to prescribers, and as a practitioner herself, who has used the Prescription Monitoring Program (PMP), that the Program's online system is not intuitive or user friendly and, as such, she has tasked the PMP program to do an internal review of the system to make it more user friendly.

Record of the Public Health Council Meeting May13, 2015 (Vote)

Commissioner Bharel asked for a motion to approve the minutes from May 13, 2015. Mr. Lanzikos requested to clarify record of his comments on long term care and medication

administration. These comments were referring to medication administration in home based and community settings, and not medication administration in long term care facilities themselves.

Dr. Woodward clarified date of minutes before the Council to be from May 13, 2015 and the Commissioner confirmed.

Dr. Woodward then made a motion to approve minutes as amended by Mr. Lanzikos. Mr. Rivera seconded the motion.

All voted in favor except Ms. Lucilia Prates-Ramos, who recused herself from the vote as she was not in attendance at the May meeting.

2. DETERMINATIONS OF NEED (DoN) (Vote)

a. DoN #1-3C41 Noble Hospital (Westfield) transfer of ownership

Bernard Plovnick, Director for the DoN program, presented the staff recommendation on DoN project #1-3C41, through which Baystate Health, Inc. would become the sole corporate member of Noble Hospital.

Following the presentation, Commissioner Bharel noted that pursuant to 105 CMR 100.603(C), “[t]he applicant and the persons who filed comments or testified at the hearing shall be afforded the opportunity to make a brief presentation to the council prior to the council taking action on the application.” She noted that she was advised that Lida Powell wished to speak, as well as representatives of Noble Hospital and Baystate Medical Center.

The Commissioner invited Ms. Lida Powell to the table.

Ms. Powell – She noted her position as a registered nurse for approximately four years at Noble Hospital in the operating room and emergency room, and as a representative of the Massachusetts Nurses Association (124 nurses represented at Noble). She noted that these nurses care deeply about the hospital and want to ensure it continues their mission to provide services to all despite race, creed, color, or economic status. While other hospitals are seen as a business or as an employer, we as clinicians know the primary role of the hospital is to serve as the health care safety net for the city of Westfield and its surrounding communities. There are more than 40,000 residents in Westfield alone and thousands more we serve in surrounding communities. More than 25,000 visit the ER each year and we serve over 4000 inpatient discharges, 44,000 outpatient visits each year. Recent community needs assessment cites heart disease, diabetes, respiratory issues, digestive issues, hepatitis, mental health and substance abuse as the biggest issues we see with our patient population. Seniors make up a large proportion of our patient population, and heart disease, diabetes, and dementia are the most highly reported concerns for them.

The same report notes that refugees and immigrants make up a large portion of the patient population, who are poor and will require inpatient and outpatient services, and face numerous challenges such as

transportation as a barrier to access to care. Similar access issues are faced by other low income patients in our community. Noble does provide transportation for its outpatient services, which is good for the community.

There are specific concerns we have about the sale we hope DPH can address in its approval process:

- any DoN approval include a provision to require Baystate to maintain Noble Hospital as a full service acute care hospital providing comprehensive services to all the community including beds and services for those with behavioral health issues;
- clear and unambiguous provision that guarantees all necessary services that are in place remain in place as long as DPH deems it necessary.
- ensure local board of trustees with real power to govern the operations of this hospital and ensure our mission is protected. In the last two years, the MNA has participated in efforts to maintain services and full service hospitals as larger systems have closed these services because these communities are poorer and/or those services were less profitable to the owner. We have seen Quincy Medical Center close despite servicing a full community. North Adams Hospital closed, and Berkshire Health System has not reopened that site as a full hospital.

MNA has been involved in a protracted effort to ensure services provided by Franklin Medical Center, a hospital of similar size and scope to Noble and owned and operated by Baystate, are not relocated to Springfield. Due to their efforts, Baystate has stepped up its efforts to maintain and enhance services in Franklin County. We hope that DPH will use this process to ensure Baystate applies a similar approach at Noble Hospital.

While not the purview of DPH, we would like to take this opportunity to publicly state the need for Baystate Health to recognize the rights of those who are unionized and also recognize the union contracts of those employees. WE ask that DPH ensure that the facility provides a safe environment for not only the patients but also for those who deliver care. Nurses are committed to working with Baystate Health and the Department to provide care to all who need it as is currently done.

The Commissioner invited representatives of Baystate Health, Inc. and Noble Hospital to the table.

Dr. Mark Keroack, President & CEO, Baystate Health, Inc.

Mr. Ronald Bryant, President & CEO, Noble Hospital

Mr. Bryant – Noble has clinical affiliation with Baystate in over 15 service lines, including labs, OB/GYN, ED transfers, trauma, infectious disease, cardiology, neurology, and stroke program. Established in the late 1890s to provide care to community, Noble Hospital is the largest employer in Westfield. To ensure continuity of care and financial stability of this community hospital under the changing reimbursement mechanisms we see, we respectfully request that this affiliation is approved. We mean a lot to this town and to this community. We have strived greatly to provide care. Our HCAHP [the Hospital Consumer Assessment of Healthcare Providers and Systems] scores are some of the highest in the

region. We firmly believe that the existence of Noble Hospital for years to come will be ensured through this affiliation with Baystate Health.

Dr. Keroack – thanks to Ron and staff for help in this transition. Long and strong affiliation with Noble, as well as three other community hospitals in the Baystate system that work very closely with our academic medical center based in Springfield. That latter system is an over 700 bed facility with an over 25% Medicaid mix and a strong commitment to the poor and underserved in Springfield. As of this morning, 95% occupied with 15 people waiting for beds. For the past two years under my leadership, we have worked to deploy our specialists out into the community to grow services there so we can keep beds open at our academic medical center for tertiary care, for which it is designed. To suggest Baystate has pursued any alternative strategy is entirely fiction. We have invested substantially in our community hospitals, most recently with a DoN for \$25M spent to refurbish operating rooms at Baystate Franklin in Franklin County. That hospital as a result of not only the investment in terms of facilities, but also in terms of specialists who travel from Springfield to Greenfield, has enjoyed unprecedented growth and prosperity and has opened additional inpatient beds. We are planning to do the same in our Eastern region, and have discussed interesting opportunities to expand services at Noble by having physicians travel out from Springfield rather than having patients travel in from Westfield. Baystate is committed to a locally driven community health needs assessment. As a system, we provide over \$100M of community support using the IRS definition, and over \$30M using the attorney general definition, and have enjoyed collaborative relationships with all community leaders in those communities we serve. We also enjoy collaborative and respectful relations under my leadership with the MNA and will continue to respect that organization and the two bargaining units in our system.

Following the presentations, Commissioner Bharel opened the floor to discussion.

Dr. Woodward – One of the questions that comes up is the issue of behavioral health, and the fact that there are 20 beds at Noble, as well as 15 rehab beds. What is the commitment of Baystate to maintain these beds in addition to maintaining medical/surgical and emergency capacity?

Dr. Keroack – With respect to rehab, this is an exciting addition to the Baystate system. We have no other rehab beds in our system. We recently expanded our capabilities for neurovascular intervention for the acute treatment of stroke, and would be looking to establish specialized units for stroke rehabilitation. The rehab unit is full most days, but there is the ability to expand it for these kinds of programs. We are jammed for beds on our neuro service, and would like to get patients into early and intensive rehab in this area. Psychiatry is a statewide problem. Every day, we have five or six patients waiting in our emergency room for days for psych beds. This would bring the total of psych beds in our system from 60 to 80, I believe. It is a crying need in terms of mental health beds. This would not address a need for pediatric psychiatric beds, but would allow us to continue serving that population. We are anticipating the report of the Governor's task force on opiate addiction, and expect some of the psych beds in our system will be used for substance abuse and recovery pursuant to those initiatives.

Dr. Woodward – Are there beds currently in the Baystate system specifically for substance abuse at this time?

Dr. Keroack - Some of them are used that way but there are none that are specifically for substance abuse programs per se.

Dr. Woodward asked about the financial viability of maintaining these services in the community environment moving forward.

Dr. Keroack – The community environment is the lower cost environment for these services, so one of the reasons we're trying to get routine care out into our community hospitals is we would lose money on every case of that nature in our Springfield hospital whereas we would break even or even make a slight margin on a routine case, either med/surg or psych in a community setting. We have no plans to change the complement of psych or rehab beds at Noble.

Mr. Lanzikos – I am prepared to fully support this application, but while we have no oversight or authority regarding the composition of the governing body, it would behoove the organization going forward to ensure the composition of the governing body is more reflective of the diverse community the hospital serves, in terms of racial composition, sexual orientation, gender identification, disability, and age.

Dr. Keroack – Diversity is a major priority of ours, and diversity in leadership one of the 15 major indicators we follow in our system-level scoreboard. I have focused since taking over as CEO last year to increase the diversity of our board – we've gone from one to three board members of color. One of the two Noble trustees is a woman, being added for her strong financial abilities but it does help our diversity efforts.

Dr. Bernstein – What is the impact of these mergers?

Dr. Keroack – I have been a part of three similar mergers, and the biggest problem is culture. What we have attempted to do with our acquisition of Baystate Wing is use a technique called appreciative inquiry where to look and see what works well with the existing culture and see how to incorporate that to improve system culture. At Wing, they had a more robust and deep implementation of LEAN performance improvement methods, and have worked to implement that into the system. We're excited to see what Noble has to offer to the new culture of a merged system. It is important to me that the Baystate brand mean the same thing from the standpoint of quality and safety and experience across the system, and that means change on both sides.

After no additional comments or questions, Commissioner Bharel asked for a motion to approve DoN Project No. 1-3C41 for the transfer of ownership of Noble Hospital to Baystate Health, Inc. Dr. Woodward made a motion to approve the DoN and Mr. Rivera seconded. All voted in favor.

b. DoN #3-3C36 Lawrence General Hospital – significant change to previously approved construction project

Bernard Plovnick, Director for the DoN program, presented the staff recommendation on a request by Lawrence General Hospital of Lawrence for a significant change to the approved DoN project #3-3C36, which is a request for significant change to increase the approved maximum capital expenditure for the project that will replace the existing operating room suite through new construction.

Following the presentation, Commissioner Bharel opened the floor to discussion.

Dr. Woodward – A 20% increase seems like a lot and it's hard to understand how original estimates could have been off by 20% a year ago. Do we believe we have an accurate estimate at this point, or will this creep up further as time goes on with unexpected conditions, etc.?

Mr. Plovnick – From my experience in facility planning and with DoN, I believe that it's common that, when working with older facilities, once you get into the project you find a number of conditions, and if you want more info the applicant can speak to that, but my understanding is that a lot of these conditions that were discovered affect the critical path of the project. You can't tear down the building until you remove all of the asbestos. The extent of the asbestos level was far above what they originally thought and there were some soil conditions that were later discovered, that both presented problems determining the critical path of the project and added to the cost.

Ms. Lynn Conover, DoN Program Analyst – The engineers did not have access to the building to be demolished at the time the DoN was filed and were limited in their ability to determine the full extent of the asbestos and the complications with tearing down the building

Dr. Woodward – Were the soil issues that you mentioned due to oil leak?

Mr. Plovnick – I am not sure specifically, but I do know that the site is close to the road so there was extra soil reinforcement required at the site so that there will be no damage to the road.

After no additional comments or questions, Commissioner Bharel asked for a motion to approve the significant change amendment to DoN Project No. 3-3C36 for Lawrence General Hospital of Lawrence. Mr. Rivera made a motion to approve the DoN and Dr. Bernstein seconded. All voted in favor.

Serious Reportable Events update

Katherine Fillo, Quality Improvement Manager for the Bureau of Health Care Safety and Quality, presented to the Council on Serious Reportable Event (SRE) data collected for 2014.

At the conclusion of the presentation, Commissioner Bharel asked the members if they had any questions

Dr. Rosenthal – I'm curious if you could tell us a bit more about what you do with the more granular data. To what extent more granular insights from root cause analyses are shared with providers? Is this done on a project-by-project basis or more routinely as an opportunity to share what people learn from certain events?

Ms. Fillo – We partner with a lot of different stakeholder groups, so the information shared from root cause analyses and corrective actions depends on the group we are participating with. For instance, there is a perinatal advisory council that represents many neonatologists in the Commonwealth so we shared information on newborn SRE data and then many of the root causes we found around communication. It led to great feedback and partnership in terms of trying to identify solutions.

Dr. Bernstein – It seems like at some point a denominator would be important, because there could be changes in volume or staffing issues also occurring. Doesn't change the fact that events are happening, but including a denominator could show these changes.

Ms. Fillo – SREs are such a small sliver of all of the different adverse events we can receive or that potentially could be reported so since there is such a low number we're still at a phase where we are encouraging reporting. For instance, there are only four or five of these events reported at community hospitals. So, we are still encouraging reporting, so to have a denominator would be a bit premature and cause for concern. But definitely in our work we look at the size of the facility and the number of patient admissions in terms of denominators.

Dr. Woodward – There were three items that struck me that were dramatic increases: burns, self-harm, and physical assaults. So, for instance with the burns: do we have a mechanism that once you've done the root cause analysis and disseminated to the hospital where the event occurred where we getting this to other providers since these events are likely to occur in other environments, as well? Are you working with BORIM and using their communication mechanisms, or are you disseminating to all hospitals when you observe a pattern or specific area of concern?

Ms. Fillo – I think there is definitely always an opportunity to share more data with stakeholders. A lot of what we share is at different meetings, like the Massachusetts Coalition for the Prevention of Medical Errors which a lot of quality improvement managers and risk managers from area facilities attend. In terms of burns, we also look at those internally and, although there are the two larger trends we see, in terms of a breakdown of the number of events at facilities is still widely spread so we weren't able to discern using qualitative methods and content analysis any other significant patterns.

Dr. Woodward – So with burns, the number has basically doubled. I know you mentioned hotpacks. Are these primarily hotpack issues, or are these inflammatory agent issues?

Ms. Fillo – So, in terms of the events that occurred within medical/surgical floors involving heatpacks, vulnerable patients or patients with lower skin integrity are more at risk. We look at these as systems issues in terms of the availability of commercial heatpacks that have some evidence and testing behind them, or also then many of the commercial heatpacks have a protective covering so one of the larger trends was that there was some type of breakdown within that process that policy and procedure wasn't followed due to lack of equipment availability and other issues.

Dr. Woodward – So, it is useful to disseminate the fact that this has doubled in the last year to all hospitals and this is an area that hyper vigilance should be applied, but are we disseminating the findings adequately?

Ms. Fillo – I think we are disseminating that adequately, but there is always room for improvement.

Dr. Woodward – Are most of the staff assaults in the ER?

Ms. Fillo – The majority occur on behavioral health units, followed by the ER.

Mr. Lanzikos – Once we gather information, do we disseminate back to facility annually? Are they required to share it within groups, such as board of trustees and senior leadership, and not just with limited groups of clinicians at the facility to generate awareness?

Ms. Fillo – Yes, absolutely. The information is shared with the facility in terms of undergoing a validation process, and it is also published on our website. Events by facility for 2014 will be on our website by the end of the week. Within the facilities, we encourage results be shared with facility leadership, and we have a question field that asks who was in charge of the facility at that time. Aside from SREs program, most of the facilities are subject to the conditions of participation for the Centers for Medicare and Medicaid Services so they have regulatory language that requires quality assurance and performance improvement for any sharing of the data. At this time, this program only requires that the information be shared with the patient and their family members or whatever loved ones might be appropriate. In terms of reading many of these reports, for the most part they are very thorough narratives and often the VP of quality or other leadership is involved. An interdisciplinary committee generally performs the root cause analysis.

Mr. Lanzikos – Do you have access to data being reported by states other states and jurisdictions, and are you able to do a comparative analysis both in terms of rates of experience and rates of change relative to the various SRE categories? And, if so, how do we compare?

Ms. Fillo – There are 27 states with adverse event reporting systems. Obviously, since they are state-developed, they are unique in some different capacities, but we do regularly interact with surrounding states. For instance, Connecticut and New Hampshire have programs similarly structured to ours and they offer annual public reports. Also, Minnesota is a great leader in patient safety, so we regularly compare with them both looking at trends and other areas. They will be releasing their data Monday, so we will work with them to compare our data. In terms of the New England area, by far we have the most facilities so we have a higher number of events. We also have a culture of transparency in the Commonwealth. However, we do look at rates of events across other states.

Dr. David – For falls, does the root cause analysis show how we can avoid these events?

Ms. Fillo – Yes, definitely. This is an area that is definitely a priority of the Secretary in addition to the Commissioner, so we are doing a lot of work to take a look at how to improve. When looking at root causes, many of the reports talk about whether bed alarms were used or not, but we're looking to encourage proactive patient rounding. We found many of the falls occur in the morning between the 7:00 and 8:00 hour. So sharing both the trends as well as the root cause analysis with all facilities has been vital to trying to reduce these events.

Ms. Prates-Ramos – I think you said that you are collecting language and ethnicity data, and that there wasn't a significant number of these groups that report an SRE and, in fact, the majority of people reporting an SRE reported a primary language of English. One of my concerns around SREs is that this has been underreported and we have very conservative numbers. The data in regards to language and ethnicity speaks to that. If you are from an immigrant community and have limited English proficiency, you are less likely to be reported as an SRE. Consumers don't not know how to report these and what to do next when they have suffered an SRE. I work to educate people about this, but I do not touch

everyone. What can we do as a Department to educate consumers about this and ensure this connection is being made so consumers know what to do next when they have suffered an SRE? How can we become more transparent about the process?

Ms. Fillo – In response to comments we've received, we previously haven't collected preferred language data, but now that it is reported in alignment our Office of Health Equity which has all available languages to be reported. More than 95% of SREs are reported by hospitals. When compared to complaints intake unit information, where patients, family members, and other stakeholders are able to call and make a complaint about a facility, there are higher levels of racial and ethnic minorities experiencing SREs. Engagement not only with patient and family advisory councils but with other stakeholders on this is very important, and would welcome your feedback on how to engage in this work more.

Dr. Bernstein – Elopements: I know this does happen frequently – what is your definition for this?

Ms. Fillo – In order for a patient to elope, they have to either not have the capacity to make decisions on their own, or be under a section 12A or 12B. There in fact could be more patients that leave the emergency department, but this is the data we have reported to us. In terms of a serious injury sustained, that would be a fracture, some type of cut that required staples or sutures, or perhaps a fall resulting in a subdural hematoma or some type of bleed in their head. The few events that have been reported thus far have been patients that were in an inpatient facility that were under close observation but managed to leave the facility.

Dr. Bernstein – Do you review legal filings of malpractice to further examine SREs?

Ms. Fillo – We do participate in Massachusetts Alliance for Communication and Resolution Following Medical Injuries, so in terms of looking at their data around conflict resolution prior to some type of legal event and comparing legal action to SREs, it is a wonderful comment and something we do take into account.

Dr. Woodward – You mentioned 95% of the events are reported by hospitals, I would expect 100%. And if there are 5% determined to be SREs reported by patients that were not reported by hospitals, then we need to reach out to the institutions to find out why not. Wouldn't it be 100% reported by hospitals, and what is follow up time?

Ms. Fillo – Correct. Over 95%, and close to 100%, are reported by hospitals or ambulatory surgical centers. There are a few every year that are reported by patients, which are then investigated by the Department. There is quick follow up with the hospitals in those instances.

Dr. Woodward – For events that are reported as a complaint that rise to the threshold of an SRE, that is a lapse on the part of the institution and should be addressed.

Ms. Prates-Ramos – I just want to point out that in my work I run into this with a lot of elders who have received care, clearly an SRE, it goes to the QIO, the QIO makes a determination, and they are encouraged to file a report with DPH. In two instances, it did not make it to DPH, and the hospital then scrambled to show that they were following that protocol. That is just two cases, but I am sure there are a lot out there.

Commissioner Bharel – Council members, thank you for your comments. This is obviously an issue that is important to us – patient safety is our top priority. It is important for us to look at trends internally, but also across states. We will continue to review this issue moving forward.

Mr. Lanzikos requested regular updates on the required regulatory review process, and what regulations could be expected moving forward. The commissioner affirmed that updates would be provided to Council as available.

Dr. Woodward – I wanted to know why the Steward monitoring presentation was postponed, since this is something we’re likely to hear more about moving forward.

Commissioner Bharel – The Steward monitoring update was postponed because there was a scheduling issue, and will be coming to Council shortly in the future.

Commissioner Bharel asked for a motion to adjourn.

The meeting adjourned at 10:37AM on a motion by Dr. Bernstein and seconded by Dr. Rosenthal. All approved.

LIST OF DOCUMENTS PRESENTED TO THE PHC FOR THIS MEETING:

1. Docket of the meeting
2. Minutes of the Public Health Council meeting of May 13, 2015.
3. DoN Pending Projects
4. DoN Memorandum on DoN Project No. 1-3c41 Noble Hospital Transfer of Ownership to Baystate Medical Center
5. DoN Memorandum on Memorandum on Lawrence General Hospital – significant change to previously approved construction project DoN Project No. 3-3C36.
6. Copy of Serious Reportable Events for 2014 power point presentation

Commissioner Monica Bharel, Chair